Greater Columbus Right to Life
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Pray for Life

State Medical Board of Ohio
Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: 03 (Month) 30 (Day) 2017 (Year)

2. Name of medical practice or facility at which RU-486 was provided: Planned Parenthood east surgical center

3. Address of medical practice or facility at which RU-486 was provided: 3255 East Main St, Columbus OH, 43213

4. Date post RU-486 complication began: 4/3/17

5. Event(s) (Please check all that apply):

X Incomplete abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

___ Other serious event (specify) _____

6. Duration of event: _____ Hours 5 Days

7. Remarks: D&C performed, uncomplicated.

8. a. Name of physician who provided RU-486: Catherine Romano MD/DO

8. b. Physician's signature: [signature]

Date: 4/4/17

Send completed forms to: State Medical Board of Ohio
Legal Department
30 E. Broad St., 3rd Floor
Columbus, OH 43215-6127

MEDICAL BOARD
APR 07 2017

Prescribed: 5/--/2011, Rev. 12/13/12

State Medical Board of Ohio
Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: 3 (Month) 31 (Day) 2017 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Planned Parenthood of Greater Ohio

3. Address of medical practice or facility at which RU-486 was provided:
25350 Rockside Rd. Bedford Heights, Ohio 44146

4. Date post RU-486 complication began: 4/6/17

5. Event(s) (Please check all that apply):

___ Incomplete abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

X Other serious event (specify) hematometra

6. Duration of event: 1 Hours ___ Days

7. Remarks: Medication abortion per FDA regimen on 3/31/17. Pt. reported heavy bleeding and cramping intermittantly on 4/5/17. Aspiration was performed on 4/6/17. pt did well post op.

8. a. Name of physician who provided RU-486 Timothy S Kress, MD

8. b. Physician's signature Timothy S Kress M.D./D.O.

Date 5/9/17

Send completed forms to: State Medical Board of Ohio
Legal Department
30 E. Broad St., 3rd Floor
Columbus, OH 43215-6127

MEDICAL BOARD
MAY 15 2017

Prescribed: 5/--/2011, Rev. 12/13/12

State Medical Board of Ohio
Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: 4 (Month) 5 (Day) 17 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Planned Parenthood

3. Address of medical practice or facility at which RU-486 was provided:
2314 Auburn Ave. Cinci, OH 45219

4. Date post RU-486 complication began:
6/27/17

5. Event(s) (Please check all that apply):

✓ Incomplete abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

___ Other serious event (specify) _____

6. Duration of event: 2 Hours _____ Days

7. Remarks:
completed w/ D&C

8. a. Name of physician who provided RU-486 Dr. Cursebary

8. b. Physician's signature [signature] MD DO

Date 7.7.2017

Send completed forms to: State Medical Board of Ohio
Legal Department
30 E. Broad St., 3rd Floor
Columbus, OH 43215-6127

MEDICAL BOARD
JUL 19 2017

Prescribed: S/--/2011, Rev. 12/13/12

State Medical Board of Ohio
Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: 04 (Month) 12 (Day) 17 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Preterm

3. Address of medical practice or facility at which RU-486 was provided:
12000 Shaker Blvd. Cleveland 44120

4. Date post RU-486 complication began:

5. Event(s) (Please check all that apply):

✓ Incomplete abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

___ Other serious event (specify) _____

6. Duration of event: 2 Hours _____ Days

7. Remarks:

8. a. Name of physician who provided RU-486 Mohammad Rezaee, M.D.

8. b. Physician's signature M Rezaee MD/DO

Date 5/6/17

Send completed forms to: State Medical Board of Ohio
Legal Department
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MEDICAL BOARD
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Greater Columbus Right to Life
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State Medical Board of Ohio
Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: 04 (Month) 13 (Day) 2017 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Planned Parenthood

3. Address of medical practice or facility at which RU-486 was provided:
3255 E. Main St, Columbus OH 43213

4. Date post RU-486 complication began:
4/28/17

5. Event(s) (Please check all that apply):

___ Incomplete abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

X Other serious event (specify) Failed Abortion

6. Duration of event: _____ Hours 15 Days

7. Remarks:

8. a. Name of physician who provided RU-486 Dr. Lowther

8. b. Physician's signature A. Lowther, MD (M.D./D.O)

Date 5/11/17

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Legal Department
30 E. Broad St., 3rd Floor
Columbus, OH 43215-6127

MEDICAL BOARD
MAY 16 2017

Prescribed: 5/--/2011, Rev. 12/13/12

State Medical Board of Ohio
Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: 4 (Month) / 14 (Day) / 17 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Planned Parenthood of Greater Ohio

3. Address of medical practice or facility at which RU-486 was provided:
25350 Rockside Rd. Bedford Heights, Ohio 44146

4. Date post RU-486 complication began:
5/2/17

5. Event(s) (Please check all that apply):

X Incomplete abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

___ Other serious event (specify) _____

6. Duration of event: 1 Hours _____ Days

7. Remarks: Med abortion process started on 4/14/17. Follow up bloodwork showed incomplete abortion. Aspiration done at PPGOH on 5/3/17 and pt. did well post-op.

8. a. Name of physician who provided RU-486 TIMOTHY S. KRESS, MD

8. b. Physician's signature Timothy S. Kress MD/DO

Date 6/15/17

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Greater Columbus Right to Life
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State Medical Board of Ohio
Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: April 24 2017
   Month Day Year

2. Name of medical practice or facility at which RU-486 was provided:
   Planned Parenthood East Surgery Center

3. Address of medical practice or facility at which RU-486 was provided:
   3255 E. Main St. Columbus, OH 43213

4. Date post RU-486 complication began:
   5/1/17

5. Event(s) (Please check all that apply):

   X Incomplete abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized

   ___ Patient received a transfusion ___ Severe bleeding

   ___ Other serious event (specify) _____

6. Duration of event: N/A Hours _____ Days

7. Remarks:
   Incomplete MAB, D&C performed 5/9/17

8. a. Name of physician who provided RU-486 Romanos

8. b. Physician's signature _____ MD/DO

   Date 5/9/17

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MEDICAL BOARD
MAY 2 2017

Prescribed: 5/--/2011, Rev. 12/13/12

State Medical Board of Ohio
Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: 4 (Month) 27 (Day) 17 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Planned Parenthood of Greater Ohio

3. Address of medical practice or facility at which RU-486 was provided:
25350 Rockside Rd. Bedford Heights, Ohio 44146

4. Date post RU-486 complication began:
5/12/17

5. Event(s) (Please check all that apply):

X Incomplete abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

___ Other serious event (specify) _____

6. Duration of event: 1 Hours ___ Days

7. Remarks: Med abortion procedure started on 4/27/17. Follow up ultrasound showed continued pregnancy. Surgical abortion done on 5/12/17 and pt. did well post-op.

8. a. Name of physician who provided RU-486 TIMOTHY S. KRESS, MD

8. b. Physician's signature Timothy S Kress MD/DO

Date 6/15/17

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Columbus, OH 43215-6127

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State Medical Board of Ohio
Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: 4 (Month) 28 (Day) 17 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Planned Parenthood

3. Address of medical practice or facility at which RU-486 was provided:
2314 Auburn Ave. Cinci, OH 45219

4. Date post RU-486 complication began: 5/5/17

5. Event(s) (Please check all that apply):

✓ Incomplete abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

___ Other serious event (specify) _____

MEDICAL BOARD
MAY 12 2017

6. Duration of event: _____ Hours 4 Days

7. Remarks:
pt. returned for D&C as she could not stay on day this was diagnosed.

8. a. Name of physician who provided RU-486 Dr. Lin

8. b. Physician's signature _____ M.D./D.O.

Date 5/9/17

Send completed forms to: State Medical Board of Ohio
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State Medical Board of Ohio
Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: 5 / 5 / 17 (Month / Day / Year)

2. Name of medical practice or facility at which RU-486 was provided:
Planned Parenthood of Greater Ohio

3. Address of medical practice or facility at which RU-486 was provided:
25350 Rockside Rd. Bedford Heights, Ohio 44146

4. Date post RU-486 complication began: 5/18/17

5. Event(s) (Please check all that apply):

X Incomplete abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

___ Other serious event (specify) _____

6. Duration of event: 1 Hours _____ Days

7. Remarks: Med abortion procedure started on 5/5/17. Followup ultrasound showed continued pregnancy. surgical abortion done 5/19/17 and pt. did well post-op

8. a. Name of physician who provided RU-486 Timothy S. Kress, MD

8. b. Physician's signature Timothy S. Kress MD/DO

Date 6/16/17

Send completed forms to: State Medical Board of Ohio
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Columbus, OH 43215-6127

MEDICAL BOARD
JUN 22 2017

Prescribed: 5/--/2011, Rev. 12/13/12

State Medical Board of Ohio
Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: 5 / 9 / 17 (Month / Day / Year)

2. Name of medical practice or facility at which RU-486 was provided:
Planned Parenthood of Greater Ohio

3. Address of medical practice or facility at which RU-486 was provided:
25350 Rockside Rd. Bedford Heights, Ohio 44146

4. Date post RU-486 complication began: 6/27/17

5. Event(s) (Please check all that apply):

X Incomplete abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

___ Other serious event (specify) _____

6. Duration of event: 1 Hours _____ Days

7. Remarks: Med abortion was initiated per FDA regimen on 5/9/17. Pt. returned for follow-up ultrasound on 6/27/17 - continuing pregnancy was confirmed. Surgical abortion was performed on 6/28/17; pt did well post-op.

8. a. Name of physician who provided RU-486 TIMOTHY KRESS, MD

8. b. Physician's signature [signature] M.D. / D.O

Date 7/19/17

Send completed forms to: State Medical Board of Ohio
Legal Department
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Columbus, OH 43215-6127

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State Medical Board of Ohio
Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: 5 (Month) / 11 (Day) / 17 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Planned Parenthood of Greater Ohio

3. Address of medical practice or facility at which RU-486 was provided:
25350 Rockside Rd. Bedford Heights, Ohio 44146

4. Date post RU-486 complication began: 5/25/17

5. Event(s) (Please check all that apply):

X Incomplete abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

___ Other serious event (specify) _____

6. Duration of event: 1 Hours _____ Days

7. Remarks: Med. ab. was initiated per FDA regimen on 5/11/17. Follow-up exam indicated an incomplete abortion - persistent gestational sac. Surgical aspiration was done on 6/16/17; Pt did well post-op.

8. a. Name of physician who provided RU-486 TIMOTHY KREES, MD

8. b. Physician's signature Timothy Krees (M.D./D.O)

Date 7/19/17

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Legal Department
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Columbus, OH 43215-6127

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State Medical Board of Ohio
Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: 5 (Month) / 12 (Day) / 17 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Planned Parenthood of Greater Ohio

3. Address of medical practice or facility at which RU-486 was provided:
25350 Rockside Rd. Bedford Heights, Ohio 44146

4. Date post RU-486 complication began: 5/26/17

5. Event(s) (Please check all that apply):

X Incomplete abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

___ Other serious event (specify) _____

6. Duration of event: 1 Hours _____ Days

7. Remarks: Med. abortion process began 5/12/17. Followup ultrasound showed continued pregnancy. Surgical abortion done 5/31/17 and pt. did well post op.

8. a. Name of physician who provided RU-486 TIMOTHY S. KRESS MD

8. b. Physician's signature Timothy S. Kress MD/DO

Date 6/15/17

Send completed forms to: State Medical Board of Ohio
Legal Department
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MEDICAL BOARD
JUN 22 2017

Prescribed: 5/--/2011, Rev. 12/13/12

State Medical Board of Ohio
Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: 5 (Month) 16 (Day) 17 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Planned Parenthood of Greater Ohio

3. Address of medical practice or facility at which RU-486 was provided:
25350 Rockside Rd. Bedford Heights, Ohio 44146

4. Date post RU-486 complication began: 6/2/17

5. Event(s) (Please check all that apply):

X Incomplete abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

___ Other serious event (specify) _____

6. Duration of event: 1 Hours _____ Days

7. Remarks:
Med. abortion was initiated per FDA regimen on 5/16/17. Follow-up bloodwork indicated a failed abortion. Surgical aspiration was done on 6/7/17; pt. did well post-op.

8. a. Name of physician who provided RU-486 TIMOTHY KRESS, MD

8. b. Physician's signature Timothy Kress (M.D./D.O)

Date 7/19/17

Send completed forms to: State Medical Board of Ohio
Legal Department
30 E. Broad St., 3rd Floor
Columbus, OH 43215-6127

MEDICAL BOARD
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Prescribed: 5/--/2011, Rev. 12/13/12

State Medical Board of Ohio
Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: 5 (Month) 16 (Day) 17 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Planned Parenthood of Greater Ohio

3. Address of medical practice or facility at which RU-486 was provided:
25350 Rockside Rd. Bedford Heights, Ohio 44146

4. Date post RU-486 complication began:
5/25/17

5. Event(s) (Please check all that apply):

X Incomplete abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

___ Other serious event (specify) _____

6. Duration of event: 1 Hours _____ Days

7. Remarks: Med. abortion process began 5/16/17. Followup bloodwork showed incomplete abortion. Aspiration done at PPFOH on 5/25/17 and pt did well post op.

8. a. Name of physician who provided RU-486 TIMOTHY S. KRESS, MD

8. b. Physician's signature Timothy S Kress MD/DO

Date 6/15/17

Send completed forms to: State Medical Board of Ohio
Legal Department
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MEDICAL BOARD
JUN 22 2017

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State Medical Board of Ohio
Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: 5 (Month) / 24 (Day) / 17 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Planned Parenthood of Greater Ohio

3. Address of medical practice or facility at which RU-486 was provided:
25350 Rockside Rd. Bedford Heights, Ohio 44146

4. Date post RU-486 complication began: 6/7/17

5. Event(s) (Please check all that apply):

X Incomplete abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

___ Other serious event (specify) _____

6. Duration of event: 1 Hours ___ Days

7. Remarks: Med. abortion was initiated per FDA regimen on 5/24/17. Follow-up ultrasound showed a continuing pregnancy. Surgical abortion was done on 6/7/17; pt did well post-op

8. a. Name of physician who provided RU-486 TIMOTHY KREESS MD

8. b. Physician's signature [signature] (M.D./D.O.)

Date 7/19/17

Send completed forms to: State Medical Board of Ohio
Legal Department
30 E. Broad St., 3rd Floor
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MEDICAL BOARD
JUL 27 2017

Prescribed: 5/-/2011, Rev. 12/13/12

State Medical Board of Ohio
Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: 5 (Month) 26 (Day) 17 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Planned Parenthood

3. Address of medical practice or facility at which RU-486 was provided:
2314 Auburn Ave. Cinci, OH 45219

4. Date post RU-486 complication began:
6/8/17

5. Event(s) (Please check all that apply):

___ Incomplete abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

✓ Other serious event (specify) ongoing pregnancy

6. Duration of event: 2 Hours _____ Days

7. Remarks:
completed surgically without issue

8. a. Name of physician who provided RU-486 Dr. Lin

8. b. Physician's signature _____ M.D./D.O.

Date 6/14/17

Send completed forms to: State Medical Board of Ohio
Legal Department
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MEDICAL BOARD
JUN 19 2017

Prescribed: 5/--/2011, Rev. 12/13/12

State Medical Board of Ohio
Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: 5 (Month) 31 (Day) 17 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Planned Parenthood

3. Address of medical practice or facility at which RU-486 was provided:
2314 Auburn Ave. Cinci, OH 45219

4. Date post RU-486 complication began:
6/1/17

5. Event(s) (Please check all that apply):

___ Incomplete abortion ___ Adverse reaction to RU-486 X Patient hospitalized

___ Patient received a transfusion X Severe bleeding

___ Other serious event (specify) _____

6. Duration of event: _____ Hours 2 Days

7. Remarks:

8. a. Name of physician who provided RU-486 Dr. Gursahany

8. b. Physician's signature Priya Gursahany M.D./D.O.

Date 6/30/2017

Send completed forms to: State Medical Board of Ohio
Legal Department
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MEDICAL BOARD
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State Medical Board of Ohio

Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

Greater Columbus Right to Life
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Pray for Life

1. Date RU-486 was provided: June (Month) 1 (Day) 2017 (Year)

2. Name of medical practice or facility at which RU-486 was provided: East Surgery Ctr. Planned Parenthood

3. Address of medical practice or facility at which RU-486 was provided:
3255 E. main St.
Columbus, OH 43213

4. Date post RU-486 complication began: 6/9/17

5. Event(s) (Please check all that apply):

___ Incomplete abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

✓ Other serious event (specify) Hematometra

6. Duration of event: _____ Hours _____ Days

7. Remarks: Patient had aspiration on 6/9/17

8. a. Name of physician who provided RU-486 Catherine Romanos

8. b. Physician's signature _____ MD/DO

Date 6/14/17

Send completed forms to: State Medical Board of Ohio
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Columbus, OH 43215-6127

MEDICAL BOARD
JUN 19 2017

Prescribed: 5/--/2011, Rev. 12/13/12

State Medical Board of Ohio
Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

Greater Columbus Right to Life
www.gcrtl.org
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1. Date RU-486 was provided: June (Month) 7 (Day) 2017 (Year)

2. Name of medical practice or facility at which RU-486 was provided: Planned Parenthood East

3. Address of medical practice or facility at which RU-486 was provided: 3255 E Main St. Columbus, OH 43213

4. Date post RU-486 complication began: 6/21/17 at MAB follow up

5. Event(s) (Please check all that apply):

✓ ~~Incomplete~~ failed abortion
___ Adverse reaction to RU-486
___ Patient hospitalized
___ Patient received a transfusion
___ Severe bleeding
___ Other serious event (specify) _____

6. Duration of event: _____ Hours _____ Days

7. Remarks: Surgical AB after medical AB on 6/22/17

8. a. Name of physician who provided RU-486 Catherine Romanos

8. b. Physician's signature _____ MD/DO

Date 6/27/17

Send completed forms to: State Medical Board of Ohio
Legal Department
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MEDICAL BOARD
JUN 28 2017

Prescribed: 5/--/2011, Rev. 12/13/12

State Medical Board of Ohio
Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: 6 (Month) 10 (Day) 17 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Planned Parenthood of Greater Ohio

3. Address of medical practice or facility at which RU-486 was provided:
25350 Rockside Rd. Bedford Heights, Ohio 44146

4. Date post RU-486 complication began: 6/22/17

5. Event(s) (Please check all that apply):

X Incomplete abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

___ Other serious event (specify) _____

6. Duration of event: 1 Hours _____ Days

7. Remarks: Med abortion initiated per FDA regimen on 6/10/17. Follow-up bloodwork and ultrasound indicated a failed abortion. Surgical aspiration was done on 6/22/17; pt. did well post-op.

8. a. Name of physician who provided RU-486 TIMOTHY KRESS, MD

8. b. Physician's signature Timothy Kress (M.D./D.O.)

Date 7/19/17

Send completed forms to: State Medical Board of Ohio
Legal Department
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MEDICAL BOARD
JUL 27 2017

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State Medical Board of Ohio

Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

Greater Columbus Right to Life
www.gcrtl.org
Pray for Life

1. Date RU-486 was provided: June ~~26~~ 13 2017
   Month Day Year

2. Name of medical practice or facility at which RU-486 was provided:
   Planned Parenthood East

3. Address of medical practice or facility at which RU-486 was provided:
   3255 E. Main St. Columbus OH 43213

4. Date post RU-486 complication began:
   June 26, 2017

5. Event(s) (Please check all that apply):

   ✓ Incomplete abortion
   ___ Adverse reaction to RU-486
   ___ Patient hospitalized
   ___ Patient received a transfusion
   ___ Severe bleeding
   ___ Other serious event (specify) _____

6. Duration of event: _____ Hours _____ Days

7. Remarks:
   6/26 - Surgical AB after incomplete Med AB

8. a. Name of physician who provided RU-486 Catherine Ramanes

8. b. Physician's signature _____ MD/DO

   Date ~~6/22/17~~ 6/27/17

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Legal Department
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Columbus, OH 43215-6127

MEDICAL BOARD
JUN 28 2017

Prescribed: 5/--/2011, Rev. 12/13/12

State Medical Board of Ohio
Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: 6 (Month) 16 (Day) 17 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Planned Parenthood of Greater Ohio

3. Address of medical practice or facility at which RU-486 was provided:
25350 Rockside Rd. Bedford Heights, Ohio 44146

4. Date post RU-486 complication began: 6/27/17

5. Event(s) (Please check all that apply):

X Incomplete abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

___ Other serious event (specify) _____

6. Duration of event: 1 Hours _____ Days

7. Remarks: Med abortion initiated per FDA regimen on 6/16/17. Follow-up ultrasound showed a continuing pregnancy. Surgical aspiration was done on 6/27/17; pt did well post-op.

8. a. Name of physician who provided RU-486 TIMOTHY KRESS, MD

8. b. Physician's signature Timothy Kress M.D./D.O.

Date 7/19/17

Send completed forms to: State Medical Board of Ohio
Legal Department
30 E. Broad St., 3rd Floor
Columbus, OH 43215-6127

MEDICAL BOARD
JUL 27 2017

Prescribed: 5/-/2011, Rev. 12/13/12

State Medical Board of Ohio

Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: 06 (Month) 17 (Day) 17 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Preterm

3. Address of medical practice or facility at which RU-486 was provided:
12000 Shaker Blvd. Cleveland 44120

4. Date post RU-486 complication began:
7/8/17

5. Event(s) (Please check all that apply):

✓ Incomplete abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

___ Other serious event (specify) _____

6. Duration of event: 1 Hours _____ Days

7. Remarks:

8. a. Name of physician who provided RU-486: Mitchell Reider, M.D.

8. b. Physician's signature _____ MD/DO

Date 7/12/17

Send completed forms to: State Medical Board of Ohio
Legal Department
30 E. Broad St., 3rd Floor
Columbus, OH 43215-6127

MEDICAL BOARD
JUL 17 2017

Prescribed: 5/--/2011, Rev. 12/13/12

State Medical Board of Ohio
Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

Greater Columbus Right to Life
www.gcrtl.org
Pray for Life

1. Date RU-486 was provided: 6 (Month) 23 (Day) 17 (Year)

2. Name of medical practice or facility at which RU-486 was provided: East Planned Parenthood

3. Address of medical practice or facility at which RU-486 was provided: 3255 E. Main St. Columbus, OH 43213

4. Date post RU-486 complication began: 7/3/17

5. Event(s) (Please check all that apply):

___ Incomplete abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

✓ Other serious event (specify) failed MAB

6. Duration of event: _____ Hours _____ Days

7. Remarks: Suction on 7/3/17 at MAB Follow up appt.

8. a. Name of physician who provided RU-486 Catherine Romanos

8. b. Physician's signature _____ MD/DO

Date 7/5/17

Send completed forms to: State Medical Board of Ohio
Legal Department
30 E. Broad St., 3rd Floor
Columbus, OH 43215-6127

MEDICAL BOARD
JUL 10 2017

Prescribed: 5/--/2011, Rev. 12/13/12

State Medical Board of Ohio

Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

Greater Columbus Right to Life
www.gcrtl.org
Pray for Life

1. Date RU-486 was provided: July (Month) 3 (Day) 2017 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Planned Parenthood East

3. Address of medical practice or facility at which RU-486 was provided:
3255 E. Main St. Columbus, OH 43213

4. Date post RU-486 complication began: 7/10/17

5. Event(s) (Please check all that apply):

X Incomplete abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

___ Other serious event (specify) _____

6. Duration of event: _____ Hours _____ Days

7. Remarks:

8. a. Name of physician who provided RU-486 Catherine Romanos

8. b. Physician's signature _____ MD/DO

Date 7/12/17

Send completed forms to: State Medical Board of Ohio
Legal Department
30 E. Broad St., 3rd Floor
Columbus, OH 43215-6127

MEDICAL BOARD
JUL 13 2017

Prescribed: 5/--/2011, Rev. 12/13/12

State Medical Board of Ohio

Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: 07 (Month) 07 (Day) 17 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Preterm

3. Address of medical practice or facility at which RU-486 was provided:
12000 Shaker Blvd. Cleveland 44120

4. Date post RU-486 complication began: 07/21/17

5. Event(s) (Please check all that apply):

✓ Incomplete abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

___ Other serious event (specify) _____

6. Duration of event: ___1___ Hours _____ Days

7. Remarks:

8. a. Name of physician who provided RU-486 Mitchell Rider, M.D.

8. b. Physician's signature _____ M.D./D.O.

Date 8/2/17

Send completed forms to: State Medical Board of Ohio
Legal Department
30 E. Broad St., 3rd Floor
Columbus, OH 43215-6127

MEDICAL BOARD
AUG 07 2017

Prescribed: 5/--/2011. Rev. 12/13/12